DEPARTMENT OF HEALTH AND HOSPITALS

Health Standards Section
License Application
CASE MANAGEMENT
SUPPORT COORDINATION

☐ *INITIAL* ☐ *RENEWAL* ☐ *OTHER* (Specify) _____ *LICENSE NUMBER* _____ *EXPIRATION DATE* _____

TOTAL FEE AMOUNT INCLUDED _____ *CHECK / MONEY ORDER #* _____

☐ **check if any change has occurred since last application** **STATE ID #CM___ ___ ___ ___ ___ ___ ___**

I. ***FACILITY (DBA) NAME*** _____

GEOGRAPHICAL ADDRESS _____

CITY / STATE / ZIP _____

TELEPHONE NUMBER (____) _____ ***FAX NUMBER*** (___) _____ ***EMAIL ADDRESS*** _____

REGION _____ ***PARISH*** _____

II. **MAILING. ADDRESS** ***(IF DIFFERENT FROM ABOVE)*** _____

CITY / STATE / ZIP _____

III. **ADMINISTRATOR** _____

AGES SERVED: ☐ *0 – 17 YRS.* ☐ *18 – OVER* ☐ *ALL AGES*

IV. **TYPE OF OWNERSHIP:**

NON- PROFIT	FOR – PROFIT	GOVERNMENT
☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *INDIVIDUAL/SOLE PROPRIETOR*	☐ *FEDERAL*
☐ *CORPORATION*	☐ *CORPORATION*	☐ *HOSPITAL DISTRICT*
☐ *PARTNERSHIP*	☐ *PARTNERSHIP*	☐ *STATE*
☐ *RELIGIOUS AFFILIATION*	☐ *GROUP PRACTICE*	☐ *CITY/PARISH*
☐ *UNINCORPORATED ASSOCIATION*	☐ *OTHER (Specify):* _____	☐ *COMBINATION GOV-N-PROFIT*
☐ *OTHER (Specify):* _____		☐ *PARISH ONLY*
		☐ *CITY ONLY*
		☐ *OTHER* _____

V. ***ENTITY / CORPORATION NAME*** _____

MAILING ADDRESS *(IF DIFFERENT)* _____

CITY / STATE / ZIP _____

TELEPHONE NUMBER (____) _____ ***FAX NUMBER*** (____) _____

VI. List name, address, and telephone numbers for persons or group of persons having direct or indirect ownership or a controlling interest (≥ 5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity ***(ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).***

OWNER	ADDRESS	TELEPHONE #

HSS-CM-01 (issued 12/05; revised 12/08; 5/10; 12/11)

CASE MANAGEMENT/SUPPORT COORDINATION LICENSE APPLICATION

VII. If the disclosing entity is a corporation, list name, address and telephone number of the President.

NAME	*ADDRESS*	*TELEPHONE NUMBER*

VIII. Are any owners of the disclosing entity also owners of other licensed health care facilities? ☐ ***Yes*** ☐ ***No***
(Proprietorship, Partnership or Board Member) If yes, list names, addresses of individuals and other provider numbers.

NAME	*ADDRESS*	*PROVIDER NUMBER*

IX. Has there been a change of ownership or control within the last year? ☐ ***Yes*** ☐ ***No*** ***If yes, give date:*** _____

X. Medicaid Provider Enrollment Number _____

XI. SERVICES TO BE PROVIDED:

☐ *NOW Waiver* ☐ *Children's Choice* ☐ *HIV Infected* ☐ *Elderly Disabled Adult*

☐ *Part H – Dev Disability Infants/Toddlers (Early Steps)* ☐ *EPSDT*

XII. Number of satellite, branch, or offsite offices (If applicable) _____

Address	*License Number*

ATTESTATION:

- ***I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Department of Health and Hospitals, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct, and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.***

_____

AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

_____ _____

AUTHORIZED REPRESENTATIVE SIGNATURE ***DATE***